

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY ST. MARY'S b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL VALLEY LEE c. LENGTH OF STAY IN 1b 22 YEARS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL VALLEY LEE d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) EARL			First		Middle		Last		4. DATE OF DEATH DECEMBER 3, 1965		
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 24, 1903		9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SAWER				10b. KIND OF BUSINESS OR INDUSTRY SAW MILL		11. BIRTHPLACE (County & State, or foreign country) GEORGIA			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME THOMAS BARNES					14. MOTHER'S MAIDEN NAME MARY ?/?						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. 220-16-2120		17. INFORMANT FLOSSIE BARNES			Address VALLEY LEE, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis DUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic gangrene both feet										INTERVAL BETWEEN ONSET AND DEATH 2 hours 3 years 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from May, 1957 , to Dec 2, 1965 , that (I) (we) last saw the deceased alive on Dec 1, 1965 , and that death occurred at 8A M, from the causes and on the date stated above.											
22a. SIGNATURE P. J. BEAN								22b. DATE SIGNED 12-3-65			
22c. PHYSICIAN'S NAME (Type) P. J. BEAN M. D.				22d. ADDRESS GREAT MILLS, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC. 5, 1965		23c. NAME OF CEMETERY OR CREMATORY ST. ANDREWS CEMETERY			23d. LOCATION (City, town or county) (State) LEONARDTOWN, MARYLAND				
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY				ADDRESS LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR DEC 6 1965		25b. REGISTRAR'S SIGNATURE Charles Judge			

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16942

20324

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL ABELL ST. PATRICKS CREEK		c. LENGTH OF STAY IN ID ABELL	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THOMAS Middle DEWEY Last BLACKISTONE		4. DATE OF DEATH Month DECEMBER Day 23 Year 1965	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 8, 1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 65 yrs. IF UNDER 1 YEAR: Months 23 Days 19 Hours 65 Min.
11. BIRTHPLACE (State or foreign country) COLTON POINT MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY BLACKISTONE		14. MOTHER'S MAIDEN NAME MYRTLE COOK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-12-2850	17. INFORMANT MARY LILLIAN BLACKISTONE ABELL, MARYLAND
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) drowning 850X DUE TO (b) 2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epilepsy INTERVAL BETWEEN ONSET AND DEATH immed		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OF CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall over board while oystering	
20c. TIME OF INJURY Month, Day, Year Hour 1100 a.m. 12-23-65 p.m.	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) St Patricks Creek	20f. (City or town) (County) (State) Abell St Marys Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William D Boyd		22. DATE SIGNED 12/24/65	
EXAMINER'S NAME (Type) WILLIAM D BOYD		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL, 1965	23b. DATE THEREOF 12/27/65	23c. NAME OF CEMETERY OR CREMATORY SACRED HEART	23d. LOCATION (City, town or county) (State) BUSHWOOD, MARYLAND
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR DEC 28 1965	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16943

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20588

1. PLACE OF DEATH e. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before edemission) e. STATE	
St. Mary's MARYLAND		Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Charlotte Hall		Charlotte Hall	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
Jack Mattingly Lumber Co.		Charlotte Hall, Md.	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last WAYMAN CAIN		Month Day Year 12 23 19 65	
5. SEX		6. COLOR OR RACE	
male		negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 35? yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
		Unknown	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>5810</u> DUE TO <u>Fatty metamorphosis of the liver</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATION		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE			

UNITED STATES DEPARTMENT OF HEALTH

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REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE

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UNITED STATES DEPARTMENT OF HEALTH

REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE

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FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16944

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20325

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLEMENTS		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last RICHARD MAURICE CARTER		4. DATE OF DEATH Month Day Year DECEMBER 28, 19 65	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 21, 1965
9. AGE (In years lost birthday) yrs. 2		10. IF UNDER 1 YEAR Months Days Hours Min. 2 5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Franklin		14. MOTHER'S MAIDEN NAME GRACE ELIZABETH CARTER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MOTHER		Address SAME AS # 2 ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO (b) XXXXXXXXXX DUE TO (c) XXXXXXXXXX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William D. Boyd M.D.		22. DATE SIGNED 12/28/65	
EXAMINER'S NAME (Type) WILLIAM D. BOYD, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 12/29/65	23c. NAME OF CEMETERY OR CREMATORY SACRED HEART	23d. LOCATION (City or Town) (County) (State) BUSHWOOD ST. MARY'S MD.
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		25a. REC'D BY REGISTRAR DEC 30 1965	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 10. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural c. LENGTH OF STAY IN 1b 9HRS 55 MIN d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Station Hospital, Patuxent River		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural, Great Mills d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sigrid Middle Birgitta Last Cobb		4. DATE OF DEATH Month December Day 7 Year 19 65	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 7, 65
9. AGE (In years last birthday) 9		IF UNDER 1 YEAR Months 9 Days 55	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Saint Mary's Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Stanley Milton Cobb		14. MOTHER'S MAIDEN NAME Elizabeth S. Rydeberg	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)		16. SOCIAL SECURITY NO. NA	
17. INFORMANT Stanley M Cobb		Address Greenview Knolls, Great Mills, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cerebral Anoxia 7625 DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardio-respiratory failure (a), stating the underlying cause last. DUE TO (c) Prematurity		INTERVAL BETWEEN ONSET AND DEATH 9 HRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7 December 19 65 to 7 December 19 65 , that (I) (we) last saw the deceased alive on 7 December 19 65 , and that death occurred at 9:52P from the causes and on the date stated above.			
22a. SIGNATURE John P. Cloherty		22b. DATE SIGNED 7 Dec 1965	
22c. PHYSICIAN'S NAME (Type) J. P. CLOHERTY LT MC USN		22d. ADDRESS Sta Hosp Pax Riv Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 12/10/65	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEM.	23d. LOCATION (City, town or county) (State) ARLINGTON, VIRGINIA
24. FUNERAL DIRECTOR'S SIGNATURE P. B. Robinson P. B. ROBINSON - LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR DEC 9 1965	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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John D. Smith

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16946

CERTIFICATE OF DEATH

20327

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b 17 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X LEONARDTOWN		d. STREET ADDRESS CHURCH	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE PATRICK S. COMBS		4. DATE OF DEATH DECEMBER 16, 19 65	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 17, 1904
9. AGE (In years lost birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIREMAN		10b. KIND OF BUSINESS OR INDUSTRY CIVIL SERVICE	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK J. COMBS		14. MOTHER'S MAIDEN NAME SUSIE ABELL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW2		16. SOCIAL SECURITY NO. 219-05-1152	
17. INFORMANT BERNARDINE G. COMBS		Address LEONARDTOWN, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure + Coma DUE TO 092X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Infectious Hepatitis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 36 hrs. 4 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that death occurred at _____ M, from causes on and on the date stated above.			
22a. SIGNATURE John F. Fenwick		22b. DATE SIGNED 12-17-65	
22c. PHYSICIAN'S NAME (Type) JOHN F. FENWICK M.D.		22d. ADDRESS LEONARDTOWN, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC. 18, 1965	
23c. NAME OF CEMETERY OR CREMATORY OUR LADY'S CHAPEL		23d. LOCATION (City or Town) (County) (State) MEDLEYS NECK, MARYLAND	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		25a. REC'D BY REGISTRAR DEC 22 1965	
ADDRESS LEONARDTOWN, MARYLAND		25b. REGISTRAR'S SIGNATURE Charles Judge	

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STATE OF CALIFORNIA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16947

CERTIFICATE OF DEATH

20328

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN,		c. LENGTH OF STAY IN 1b D.O.A.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL ABELL		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM EDWARD DIXON SR.		4. DATE OF DEATH Month Day Year DECEMBER 21, 19 65	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH OCT. 15, 1876
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? ?		14. MOTHER'S MAIDEN NAME ? ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT HERMAN W. DIXON		Address ABELL, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerotic heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 30 min 20 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE John F. Fenwick		22b. DATE SIGNED 12-22-65	
22c. PHYSICIAN'S NAME (Type) JOHN F. FENWICK M. D.		22d. ADDRESS LEONARDTOWN, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/23/65	
23c. NAME OF CEMETERY OR CREMATORY TRINITY MEMORIAL GARDENS		23d. LOCATION (City or Town) (County) (State) WALDORF, CHARLES, Md.	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		25a. REC'D BY REGISTRAR DEC 27 1965	
ADDRESS LEONARDTOWN, MARYLAND		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

16948
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
20329

1. PLACE OF DEATH a. COUNTY Saint Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Saint Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River, Maryland				c. LENGTH OF STAY IN 1b Lexington Park, Maryland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Station Hospital, USNAS PAX RIV MD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John Douglas Fenton				4. DATE OF DEATH December 14 1965			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 31, 1965	9. AGE (In years last birthday) yrs. 3		IF UNDER 1 YEAR Months 17 Days 17 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Don Joseph Fenton			
14. MOTHER'S MAIDEN NAME Virginia E. Jackson				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			
16. SOCIAL SECURITY NO.				17. INFORMANT 63 Salamaua Court Father Lexington Park, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration 9210 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							INTERVAL BETWEEN ONSET AND DEATH immediate
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Aspirated vomitus			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 8:15 p.m. 12-14 1965				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Lexington Park				20g. (County) St Mary's Md		20h. (State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE E. L. Marcus				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) E. L. MARCUS, LT MC USNR				M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22. DATE SIGNED 12-15-65			
Address (Street, city, town, or county) Station Hospital, NAS Patuxent Riv Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) Transit		23b. DATE THEREOF 12/15/65		23c. NAME OF CEMETERY OR CREMATORY Jasper, Alabama		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR P.B. Robinson - Leonardtown, Maryland				25a. REC'D BY REGISTRAR DEC 17 1965			
25b. REGISTRAR'S SIGNATURE Charles J. J.							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
16949					20330				
1. PLACE OF DEATH a. COUNTY St. Marys b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Marys Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chaptico d. STREET ADDRESS Rural e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) MAY REEDER FOWLER			4. DATE OF DEATH December 27 19 65		5. SEX female				
6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11 / 30 / 1891		9. AGE (in years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (County & State, or foreign country) Morganza, Maryland			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John H. Reeder				14. MOTHER'S MAIDEN NAME Mary Dallam					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. -----		17. INFORMANT Zack M. Fowler - same as # 2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Infarction DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 12-26 , 19 65 , to 12-27 , 19 65 , that (I) (we) last saw the deceased alive on 12-26 , 19 65 , and that death occurred at 1245 M, from the causes and on the date stated above. 22a. SIGNATURE Wm. D. Boyd M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 12/27/65 22c. PHYSICIAN'S NAME (Type) Wm. D. Boyd, M.D. 22d. ADDRESS Leonardtwn, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12/30/65		23c. NAME OF CEMETERY OR CREMATORY All Faith Cemetery			23d. LOCATION (City, town or county) (State) Charlotte Hall, Maryland	
24. FUNERAL DIRECTOR P.B. Robinson P.B. Robinson - Leonardtown, Maryland					25a. REC'D BY REGISTRAR DEC 29 1965		25b. REGISTRAR'S SIGNATURE Charles Judge		

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16950

CERTIFICATE OF DEATH

20331

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN,		c. LENGTH OF STAY IN 1b 7 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL MECHANICSVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL			f. STREET ADDRESS MECHANICSVILLE		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) HAROLD GREENWELL GRAVES			4. DATE OF DEATH Month DECEMBER Day 16 Year 1965		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 6, 1905	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING.		11. BIRTHPLACE (County & State, or foreign country) MERYLAND, MECHANICSVILLE U.S.A.	
13. FATHER'S NAME ZACHARICK SAMSON GRAVES			14. MOTHER'S MAIDEN NAME JANE ELIZABETH BISCOE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES		16. SOCIAL SECURITY NO. 217-36-6337		17. INFORMANT Address EDNA B. GRAVES MECHANICSVILLE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1939 Neurosarcoma - Vagus nerve DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 6 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Jan 1958, to Dec 16, 1965, that (I) (we) last saw the deceased alive on Dec 14 1965, and that death occurred at 3 A M, from causes on and on the date stated above.					
22a. SIGNATURE <i>J Roy Luythes</i>			22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) J Roy Luythes
22d. ADDRESS MECHANICSVILLE, MARYLAND			22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/18/65		23c. NAME OF CEMETERY OR CREMATORY MT. ZION	
23d. LOCATION (City or Town) (County) (State) LAUREL GROVE, MARYLAND		24. FUNERAL DIRECTOR ADDRESS W, CLARKE MATTINGLEY LEONARDTOWN, MD.			
25a. REC'D BY REGISTRAR DATE DEC 22 1965		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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STATE OF NEW YORK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16951

20332

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b 10 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL BUSHWOOD		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM MARSHALL HALL		4. DATE OF DEATH Month Day Year DECEMBER 22, 19 65	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 7, 1887
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN WASHINGTON HALL		14. MOTHER'S MAIDEN NAME BETTY ELIZABETH NEVITT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS AGNES M. DOWNS		Address AVENUE, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Collapse 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumonia DUE TO (c) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH hrs days yes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1965 to 12/22 1965 , that (I) was last saw the deceased alive on 12/22 1965 , and that death occurred at 8:30 PM , from causes and on the date stated above.			
22a. SIGNATURE J. Patrick Jarboe M.D.		22b. DATES SIGNED 12/24/65	
22c. PHYSICIAN'S NAME (Type) J. PATRICK JARBOE M.D.		22d. ADDRESS GREAT MILLS, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC. 24, 1965	
23c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEMETERY		23d. LOCATION (City or Town) (County) (State) B. SHWOOD, MARYLAND	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		25. REGD BY REGISTRAR DEC 28 1965	
ADDRESS LEONARDTOWN, MARYLAND		25b. REGISTRAR'S SIGNATURE Charles Judge	

1885

CERTIFICATE OF DEATH

1885

T. A. V. I.

W. A. V. I.

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20333

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE North Carolina b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b Wallace 70x.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last NORMAN A. HENDERSON		4. DATE OF DEATH Month Day Year December 26 19 65	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1935
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	9. AGE (in years last birthday) 30 yrs.
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Norman Henderson		14. MOTHER'S MAIDEN NAME Lousia Dail	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFIRMANT Address Louisa Henderson Rt. 2 Wallace, N.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration complicating fatty infiltration 5810 due to of the liver Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		22. DATE SIGNED 12-27-65	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-30-65	23c. NAME OF CEMETERY OR CREMATORY Henderson Family Cemetery
24. FUNERAL DIRECTOR Ullrich Funeral Home Balto., Md.,		23d. LOCATION (City, town or county) (State) Dukeland Co., N.C.	
25a. REC'D BY REGISTRAR DATE DEC 29 1965		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

13031

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1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16953

20334

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL MECHANICSVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MECHANICSVILLE			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS XXXXXXXXX CAPT ST. MARY'S			
3. NAME OF DECEASED (Type or print) First CHRISTE Middle KONSTANTINE Last HENES				4. DATE OF DEATH Month DECEMBER Day 23 Year 1965			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 24, 1894	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GREECE		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME KONSTANTINE HENES				14. MOTHER'S MAIDEN NAME ? ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 577-48-1608		17. INFORMANT MRS DEJANIRA HENES SAME AS # 2 ABOVE		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Coronary Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH immed
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE W.D. Boyd				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) WILLIAM D. BOYD M. D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 12-27-65		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY	
24. FUNERAL DIRECTOR ROBERT E. WILHELM				ADDRESS 4308 SUTLAND RD. SUTLAND, MD		25a. REC'D BY REGISTRAR DEC 28 1965	
				25b. REGISTRAR'S SIGNATURE J. Charles Judge		23d. LOCATION (City, town or county) (State) SUTLAND, MARYLAND	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LEONARDTOWN c. LENGTH OF STAY IN 1b 7 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ST. MARY'S HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL ST. GEORGE ISLAND d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First HAROLD Middle LELAND Last HUDSON			4. DATE OF DEATH Month DECEMBER Day 8 Year 1965						
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 20, 1898		9. AGE (In years last birthday) 67 yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RAILROAD			10b. KIND OF BUSINESS OR INDUSTRY RAILROAD			11. BIRTHPLACE (County & State, or foreign country) VERMONT		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME MARSHALL HUDSON					14. MOTHER'S MAIDEN NAME EMMA PEASE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 009-09-2297		17. INFORMANT RACHEL SPRAGUE HUBSON			Address ST. GEORGE ISLAND,		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema (b) pneumothorax (c) pulmonary embolism, pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.									
22a. SIGNATURE J. C. Roa M.D.					22b. DATE SIGNED DEC 13 1965			22c. PHYSICIAN'S NAME (Type) J. C. ROA M. D.	
22d. ADDRESS LEXINGTON PARK, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Dec. 11, 1965		23c. NAME OF CEMETERY OR CREMATORY MEETING HOUSE ROAD CEMETERY		23d. LOCATION (City, town or county) (State) HINSDALE, NEW HAMPSHIRE			
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND					25a. REC'D BY REGISTRAR DEC 13 1965		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>		

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RURAL ST. GEORGE ISLAND

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Handwritten notes and signatures

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16955

20336

1. PLACE OF DEATH a. COUNTY St. Marys ¹ MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Patuxent River, Md. 21 years c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Station Hospital, U.S. Naval Air Stat. Patuxent Beach, Rd.				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys ¹ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) California d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) James William KELLY		4. DATE OF DEATH December 26 1965		Month Day Year			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH June 30, 1896		9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USN (Retired)		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (County & State, or foreign country) West Virginia			
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Kelly					
14. MOTHER'S MAIDEN NAME Laveri Blackford		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes 1917 to 1945					
16. SOCIAL SECURITY NO. 213 54 7620		17. INFORMANT (Wife) Donna A. KELLY #2		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Ischemic Heart Disease Chronic Obstructive Emphysema				INTERVAL BETWEEN ONSET AND DEATH 17 days 5-10 yrs. 5-10 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 9 December, 1965 to 26 December 1965, that (I) (we) last saw the deceased alive on 26 December 1965, and that death occurred at 1:30 AM, from the causes and on the date stated above.					
22a. SIGNATURE E. L. Marcus		22b. DATE SIGNED 26 December 65		22c. PHYSICIAN'S NAME (Type) E. L. MARCUS, LT MC USNR			
22d. ADDRESS Station Hospital, USNAS Patuxent River, Maryland		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> 22f. MED. DIRECTOR <input type="checkbox"/> 22g. STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 12/29/65		23c. NAME OF CEMETERY OR CREMATORY J.Wm.Lee Crematory			
23d. LOCATION (City, town or county) (State) Washington, D.C.		24. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Maryland					
25a. REC'D BY REGISTRAR DEC 29 1965		25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

RECUS

1033

U.S. Johnson - Washington, D.C.

12/2/52

Washington, D.C.

Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

<div>4</div> <div>1</div> <div>16956</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> <div>20337</div>											
1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Patuxent River</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Station Hospital, NAS, Patuxent River</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Patuxent River</u> d. STREET ADDRESS <u>Qtrs. P, MOQ</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Lizer</u> Last <u></u>						4. DATE OF DEATH Month <u>December</u> Day <u>29</u> Year <u>1965</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 25, 1883</u>		9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Stearns Co. MINN.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>			
13. FATHER'S NAME <u>Benjamin Veeder</u>						14. MOTHER'S MAIDEN NAME <u>Elizabeth Colthorp</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>501-40-5329</u>		17. INFORMANT <u>Loren C. Whitney</u>		Address <u>Same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetic Coma</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause last. DUE TO (c) <u></u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dehydration</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u></u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 29, 1965</u> to <u>Dec. 29, 1965</u> , that (I) (we) last saw the deceased alive on <u>Dec. 29, 1965</u> , and that death occurred at <u>10:55 M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>E. L. Marcus</u> M.D.						22b. DATE SIGNED <u>Dec 29, 1965</u>					
22c. PHYSICIAN'S NAME (Type) <u>E. L. MARCUS, LT MC USN</u>						22d. ADDRESS <u>Same as 1d</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transit</u>				23b. DATE THEREOF <u>12/30/65</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Watford City, North Dakota</u>				23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>P.B. Robinson</u> ADDRESS <u>Leonardtown, MD.</u>						25a. REC'D BY REGISTRAR <u>JAN 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

30387

RECORDS OF DEATH

30387

Stinson Cotton

Benjamin Vester

1914-1915

Stinson Cotton

1914-1915

Benjamin Vester

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16957

CERTIFICATE OF DEATH

20338

1. PLACE OF DEATH a. COUNTY <u>St. Marys</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Marys</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - California</u>		c. LENGTH OF STAY IN 1b <u>15 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>California</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rt: #2 Box 160</u>				d. STREET ADDRESS <u>Rt: # 2 Box 160</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NELSYE</u> Middle <u>JAMES</u> Last <u>NEWTON</u>		4. DATE OF DEATH Month <u>December</u> Day <u>9</u> Year <u>19 65</u>					
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12 / 26 / 1900</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>217 52 8205</u>		17. INFORMANT <u>Herbert A. Newton - same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Intestinal tract</u> <u>1539</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 7th</u> , 19 <u>65</u> , to <u>Dec 9th</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Dec 9th</u> , 19 <u>65</u> , and that death occurred at <u>8 p.m.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles Greenwell</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/10/65</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles Greenwell, MD</u>				22d. ADDRESS <u>Leonardtown, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/13/65</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Columbia Gardens Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>P.B. Robinson - Leonardtown, Md.</u>				25a. REC'D BY REGISTRAR <u>DEC 15 1965</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
16958					20339										
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)										
a. COUNTY Saint Mary's MARYLAND					a. STATE Maryland b. COUNTY Saint Mary's										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River, Maryland					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Town Creek										
c. LENGTH OF STAY IN 1b 2 HRS															
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Station Hospital, Patuxent River, Md.					d. STREET ADDRESS 107 Elm Court										
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year						
Eunice			Hynds			Smith			December 3 19 65						
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
Female		Cauc				FEB. 20, 1899									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) New Haven Connecticut				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME ? ?						14. MOTHER'S MAIDEN NAME ? ?									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 036-24-8598		17. INFORMANT Peter T. Smith 107 Elm Court Maryland				Address Town Creek					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 2 hrs.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 3 DEC 1965 to 3 DEC 1965, that (I) (we) last saw the deceased alive on 3 DEC 1965, and that death occurred at 1:40 from the causes and on the date stated above.															
22a. SIGNATURE Frank J. Konicek M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) F. J. KONICEK LT MC USNR						22d. ADDRESS Sta Hosp Pax Riv Md									
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION				23b. DATE THEREOF Dec. 4, 1965		23c. NAME OF CEMETERY OR CREMATORY XXXXX CEDAR HILL				23d. LOCATION (City, town or county) (State) SUTLAND, MARYLAND					
24. FUNERAL DIRECTOR'S SIGNATURE W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND						ADDRESS		25a. REC'D BY REGISTRAR DEC 6 1965		25b. REGISTRAR'S SIGNATURE Charles Judge					

DATE: 11/11/1964

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11. 10. 1950. 1. 1. 1951.

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16959

20340

1. PLACE OF DEATH a. COUNTY <u>St. Marys</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Marys</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Mechanicsville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Mechanicsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rural</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>EDWARD</u> Last <u>SOMERVILLE</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>13</u> Year <u>19 65</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/1/1927</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	9. AGE (In years last birthday) <u>38</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Eddie Somerville</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Shade</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218 24 7041</u>	
17. INFORMANT <u>Mary E. Bush</u>		Address <u>same as # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>3220 Aspiration</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>acute alcoholism</u> DUE TO (b) (c) INTERVAL BETWEEN ONSET AND DEATH <u>immed</u> <u>3hr</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>aspirated vomitus</u>	
20c. TIME OF INJURY Month, Day, Year <u>2:30 a.m. 12-13 1965</u>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Starlite Club</u>	20f. (City or town) (County) (State) <u>Charlotte Hall St Marys Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Wm. D. Boyd</u>		22. DATE SIGNED <u>12-15-65</u>	
EXAMINER'S NAME (Type) <u>Wm. D. Boyd</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/16/65</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Charlotte Hall, Maryland</u>
24. FUNERAL DIRECTOR <u>P.B. Robinson - Leonardtown, Maryland</u>		25a. REC'D BY REGISTRAR <u>DEC 17 1965</u>	
		25b. REGISTRAR'S SIGNATURE <u>John A. Judge</u>	

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1. PLACE OF DEATH a. COUNTY ST. MARY'S		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SCOTLAND		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) HENRIETTA		4. DATE OF DEATH Month 12 Day 10 Year 1965	
5. SEX FEMALE		6. COLOR OR RACE COLORED	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 15, 1884	
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 10 19 65	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) ST. MARY'S Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM SHORTER		14. MOTHER'S MAIDEN NAME SARAH JANE SWANN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 214-16-3881	
17. INFORMANT KATHLEEN WHITE		Address SCOTLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Collapse 192X OUE TO Septicemia & Carcinomatous Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO Tumor of eye (b) 6 mo (c) 6 mo		INTERVAL BETWEEN ONSET AND DEATH had no 6 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 11/5 , 19 65 , to 12/10 , 19 65 , that (I) (we) last saw the deceased alive on 12/10 , 19 65 , and that death occurred at 5:00 A.M. from the causes and on the date stated above.			
22a. SIGNATURE JAMES P. JARBOE		22b. DATE SIGNED 12/11/65	
22c. PHYSICIAN'S NAME (Type) JAMES P. JARBOE, M.D.		22d. ADDRESS GREAT MILLS, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC. 13, 1965	
23c. NAME OF CEMETERY OR CREMATORY ST. LUKES CEMETERY		23d. LOCATION (City, town or county) (State) SCOTLAND, MARYLAND	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		25a. REC'D BY REGISTRAR DEC 16 1965	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS LEONARDTOWN, Md.	

1200

1200

Handwritten signature: James H. [illegible]

Handwritten notes:
11/11/12
11/11/12
11/11/12

Handwritten signature: [illegible]

W. CLARE PATTON
1200
11/11/12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY ST. MARY'S b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) DRAYDEN c. LENGTH OF STAY IN 1b LIFE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) DRAYDEN d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First SARAH Middle M. Last WHALEN			4. DATE OF DEATH Month DECEMBER Day 11 Year 1965						
5. SEX FEMALE		6. COLOR OR RACE COLORED		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 12, 1880		9. AGE (In years last birthday) 85 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE			10b. KIND OF BUSINESS OR INDUSTRY HOME			11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRED EXX GLADDEN					14. MOTHER'S MAIDEN NAME LETTIE YOUNG				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. NONE		17. INFORMANT ADELADE W. BROWN Address DRAYDEN, MARYLAND				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arterio sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH 3 hours 1 1/2 years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from May 1, 1960 , to Dec 11, 1965 , that (I) (we) last saw the deceased alive on Dec 9, 1965 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.									
22a. SIGNATURE P. J. BEAN M. D.								22b. DATE SIGNED 12/12/65	
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS GREAT MILLS, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF DEC. 15, 1965		23c. NAME OF CEMETERY OR CREMATORY ST. MARKS CEMETERY		23d. LOCATION (City, town or county) (State) VALLEY LEE, MARYLAND		
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY					25a. REC'D BY REGISTRAR DEC 22 1965		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY ST. MARY'S		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b 4 DAYS		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ST. MARY'S	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ST. MARY'S HOSPITAL						d. STREET ADDRESS RURAL VALLEY LEE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DEBORAH Middle LYNN Last YOUNG			4. DATE OF DEATH Month DECEMBER Day 1 Year 1965						
5. SEX FEMALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 16, 1965		9. AGE (In years last birthday) Months 4 Days 14 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES L. MORGAN						14. MOTHER'S MAIDEN NAME REBECCA YOUNG			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT MOTHER		Address VALLEY LEE, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Enterocolitis									INTERVAL BETWEEN ONSET AND DEATH 4 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 25, 1965 , to Dec 1, 1965 , that (I) (we) last saw the deceased alive on Nov 30, 1965 , and that death occurred at 4 A.M. , from the causes and on the date stated above.									
22a. SIGNATURE P.J. BEAN M.D.						22b. DATE SIGNED 12/2/65			
22c. PHYSICIAN'S NAME (Type) P.J. BEAN M.D.						22d. ADDRESS GREAT MILLS, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC. 2, 1965		23c. NAME OF CEMETERY OR CREMATORY ST. GEORGE CEMETERY		23d. LOCATION (City, town or county) (State) VALLEY LEE, MARYLAND			
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY						25a. REC'D BY REGISTRAR DEC 6 1965		25b. REGISTRAR'S SIGNATURE Charles Judge	

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